

**Directions:** Please answer the following questions below and either fax or scan/e-mail your answers back to Mindi Matthews at the Indiana State Department of Health by Wednesday, December 16<sup>th</sup>. Thank you.

**Fax Number:** 317.233.7805

**E-mail:** [diabetes@ISDH.IN.gov](mailto:diabetes@ISDH.IN.gov)

**Area Agency & Contact Information:**

**Area Agency Name:** \_\_\_\_\_

**Trainer Name:** \_\_\_\_\_

**Trainer Phone:** \_\_\_\_\_

**Trainer E-mail Address:** \_\_\_\_\_

**Trainer Fax Number:** \_\_\_\_\_

**Trainer Certification Level (Check ONLY One):**

- ☐ Stanford Trainer ☐ Master Trainer  
☐ Lay Leader Trainer ☐ Other: \_\_\_\_\_

**What certification class did you attend to become a trainer? (Check ONLY One)**

- ☐ October 2008 ☐ May 2009  
☐ Other: \_\_\_\_\_

**Class Information:**

**Have you completed or are in process of teaching two workshops (at minimum) per the training requirements?**

*Example 1: Certification Class October 2008 - Two workshops completed by October 2009.*

*Example 2: Certification Class May 2009 – Two workshops completed or in process by May 2010.*

- ☐ Yes ☐ No

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_

**Who is your teaching partner?** \_\_\_\_\_

**Do you have a class currently being taught?** ☐ Yes ☐ No

If yes, please provide the following information:

**Location:** \_\_\_\_\_

**What session are you currently on?** 1 2 3 4 5 6

**Date(s) & Time(s):** \_\_\_\_\_

**Number of Participants:** \_\_\_\_\_

**What are your current plans for teaching 2010 workshops in your service area? (Please provide as much detail as possible, dates/months, times, locations, etc.).**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Training Information:**

**Stanford Trainers or Master Trainers - Do you have any Lay Leader Trainers under your advisement?**

If yes, please list his/her name(s): \_\_\_\_\_

**Stanford Trainers or Master Trainers - If you were to help host a Lay Leader Trainer Training in 2010, which month(s) would be best for you?**

*Note: You are not subjected to this month, but we are just looking for guidance in possibly setting these trainings up in 2010.*

☐ January

☐ April

☐ July

☐ October

☐ February

☐ May

☐ August

☐ November

☐ March

☐ June

☐ September

☐ December

**Have you identified any individual or organizations/groups to become leaders?**

☐ Yes

☐ No

*If yes, please provide information below:*

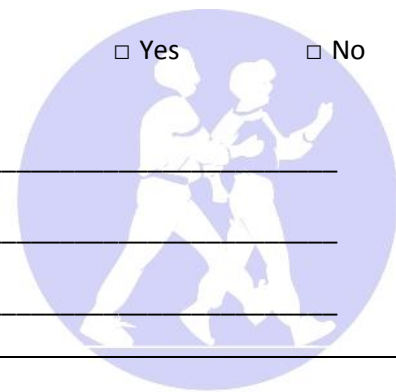
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**Marketing Information:**

**To allow us to help you market the CDSMP within your service area, please provide us with the following information (if applicable):**

*Note: Please provide us with as much of information as possible (name(s), location(s), phone number(s), etc.).*

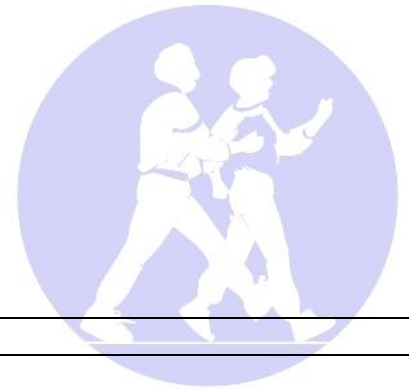
Parish Nurse Programs:

Senior Centers:

Long Term Care Facilities (assisted living):

Clubs and Organizations (Lion's Clubs, Elks, American Legion, etc.):

Major Healthcare Organizations (hospitals, specialists, etc.):



**Additional Comments:**

Living a Healthy Life  
With Chronic Conditions

Thank you.